

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS3091AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/29/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE BRIDGE AT PARADISE VALLEY ASSISTED LIVIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2205 EAST HARMON AVE.</b> <b>LAS VEGAS, NV 89119</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation initiated on 10/21/09 and completed on 4/29/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 91 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, eighty-one (81) Category I residents and ten (10) Category II residents. One resident file was reviewed.  Complaint #NV00023419 was substantiated. See Tag Y850 and Y515.	Y 000		
Y 515 SS=F	449.259(1)(a) Supervision of Residents  NAC 449.259 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary.  This Regulation is not met as evidenced by: Based on record review and interview on from 10/21/09 through 4/29/10, the facility failed to ensure 1 of 1 sampled residents was provided protective supervision as necessary (Resident	Y 515		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 515	Continued From page 1 #1).  Severity: 2    Scope: 3	Y 515			
Y 850 SS=F	449.274(1)(a) Medical Care of Resident  NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available.  This Regulation is not met as evidenced by: Based on record reviews and interviews from 10/21/09 to 3/11/10, the facility failed to notify a resident's physician when the resident became ill (Resident #1).  Severity: 2    Scope: 3	Y 850			

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